OMB Control No: 0970-XXXX
Expiration date: XX/XX/XXXX

Initial Dental Exam

General Information (to be completed by shelter staff)

Child	Last name:		First name:	
	DOB: ____/____/______	A#:		Gender:
Healthcare Provider	Name:	Phone number:	Clinic or Practice:	
	Street address:	City or Town:	State:	Date of visit: ____/____/______
Program	Name of program staff with child:		Program name:	

Assessment and Plan (To be completed by clinician)

Assessment: Check all that apply and describe where applicable.

- € Well-child/No obvious problem
- € Broken tooth or teeth:
- € Gingivitis/gum disease:
- € Impacted tooth or teeth:
- € Infection or abscess:
- € Tooth decay/caries:
  If yes, how many?
- € Tooth sensitivity:
- € Other, specify:

Plan: Check all that apply and specify in the space provided.

Return to clinic:

- € PRN/As needed
- € Follow-up (specify condition, timing):
  ____
  ____
- € Referred to specialist; specify:
- € Other, specify:

Additional Information:

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